



Camper Name: _____ 1

MILE HIGH SUMMER CAMP CAMPER REGISTRATION FORM

Colorado Chapter, National Hemophilia Foundation
1385 S. Colorado Blvd. Suite #610
Denver, CO 80222
(720) 545-0755

Please fill this form out COMPLETELY. All information is necessary for the infirmary staff to care for your child at camp. If any information changes prior to camp, please contact the Hemophilia Center at University of Colorado to update the information.

A COMPLETE SET OF FORMS MUST BE PROVIDED FOR EACH CAMPER, EVEN IF THEY DO NOT HAVE A BLEEDING DISORDER.

CAMPER INFORMATION:

Camper's Full Name: _____ T-Shirt Size: _____

Age: _____ Date of Birth: ____/____/____ Gender: M F Grade in School (in the fall) _____

Address: _____

City: _____ State: _____ Zip: _____

CONTACT INFORMATION:

Mother/Guardian Name: _____ **Employer Name:** _____

Address (If different from child's): _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-Mail: _____

Father/Guardian Name: _____ **Employer Name:** _____

Address (If different from child's): _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-Mail: _____

EMERGENCY CONTACT INFORMATION:

If parents cannot be reached, who should we call?

First Contact: Name: _____ Relationship to child: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Second Contact: Name: _____ Relationship to child: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

A PARENT OR AN ADDITIONAL PERSON MUST BE AVAILABLE FOR CONTACT 24 HOURS/DAY

INSURANCE INFORMATION:

Insurance Co.: _____ Policy #: _____

Name of Policy Holder: _____ Group #: _____

HEALTH CARE PROVIDER INFORMATION:

Primary Care Physician Name: _____ Phone #: _____

Date of Camper's Last Examination: _____

Camper Name: _____ 2

CURRENT OR RECURRING MEDICAL CONDITIONS:

This information is so medical staff can better care for your child while at camp. Please check all that apply:

<input type="checkbox"/> ADHD	<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Diabetes (attach diet)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sleep walking	<input type="checkbox"/> Other Infectious Diseases
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Bowel/Bladder Problems	
<input type="checkbox"/> Emotional/behavioral or learning	<input type="checkbox"/> Hay Fever	
<input type="checkbox"/> Asthma or other breathing problems*	<input type="checkbox"/> Allergies to food, nuts, bee or wasp stings*	

*If your child sometimes has asthma and rarely uses an inhaler or takes other asthma medication when needed, send the labeled inhaler and /or medicine to camp *even if there has not been a flare up recently*.

*If your child has allergies to stings, bites or food that require an Epi-Pen injection, send the kit with your child to camp.

Please provide more specific information about health conditions checked above including treatment needed while at camp:

Food or drug allergies: _____

List any target or problem joints, any bone or muscle problems: _____

Serious illness or surgeries within past year: _____

Dietary Restrictions: _____

IMMUNIZATIONS:

(Fill out or provide current vaccination record)

Up to Date?
(circle)

Date of Last Vaccination

Diphtheria/Tetanus/Pertussis [DTaP] Yes No _____

Varicella (Chicken Pox): Yes No _____

Polio Vaccine: Yes No _____

Measles/Mumps/Rubella [MMR] Yes No _____

Measles Vaccine: Yes No _____

Hepatitis A: Yes No _____

Hepatitis B: Yes No _____

BLEEDING DISORDER INFORMATION:

Type of Bleeding Disorder: _____ Hemophilia A/factor VIII _____ Hemophilia B/factor IX
 _____ Hemophilia Carrier with symptoms _____ von Willebrand disease
 _____ Hemophilia Carrier with NO symptoms _____ Platelet Disorder
 _____ No Bleeding Disorder (*Skip rest of page 3 and continue on page 4*)

Hemophilia Severity: _____ Severe _____ Moderate _____ Mild

Von Willebrand Type: _____ Type 1 _____ Type 2 _____ Type 3 _____ Unsure

Does your child have an inhibitor? _____ Yes _____ No

Weight: _____ Height: _____ Factor Level: _____ %

Treatment Product Name: _____

Is your child on a prophylaxis treatment regimen? _____ Yes _____ No

If yes, what is the dosing and weekly schedule? _____

Does your child self-infuse? _____ Yes _____ No

Is your child on home infusion? _____ Yes _____ No If yes, who does the infusion at home? _____

Does your child use Amicar or Lysteda? _____ Yes _____ No When? _____

Does your child have a central line? _____ Yes _____ No If yes, what type? _____

If your child has a central line, please send all supplies necessary for line access.

Additional comments about infusing your child: _____

*****PLEASE SEND ENOUGH FACTOR FOR SCHEDULED PROPHYLACTIC INFUSIONS AND EXTRA TRAUMA DOSES IN CASE OF BLEEDING. FOR CAMPER'S WITH MODERATE OR MILD DIAGNOSES, FACTOR IS STILL NECESSARY TO HAVE ON HAND. CHECK EXPIRATION DATES PRIOR TO CAMP.*****

INFUSION INSTRUCTION CONSENT:

At camp, your child will have the opportunity to learn self-infusion/infusion instruction on a voluntary, informal and individual basis by trained medical staff. Your child can receive this important training when he/she needs factor replacement during camp, but only if the child is voluntarily ready to infuse himself/herself or their sibling. This training is also available to children who may not need to infuse for medical necessity.

I grant permission for my child to receive infusion instruction.

X Parent/Guardian _____ **Date:** _____

PERMISSION TO TREAT HEMOPHILIA AND OTHER MEDICAL CONDITIONS AT CAMP:

I grant permission for my child to receive treatment for bleeding disorders (including infusion of factor and/or accessing port) and general medical conditions, including minor injuries, while at camp.

X Parent/Guardian _____ **Date:** _____

MEDICAL RELEASE FOR TREATMENT AWAY FROM CAMP:

In case of medical and/or surgical emergency, I authorize the Hemophilia Camp medical staff to provide or to arrange for my child (camper's full name): _____ to receive any x-ray, anesthetic, medical, dental, surgical procedure, treatment and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in Colorado.

In the event of a medical emergency, I grant permission for my child to be transported or transferred [taken] to a medical facility for treatment and care at the discretion of the camp medical staff.

I will be responsible for all costs incurred for emergency, inpatient or outpatient care. I understand that my child will be covered solely by the medical insurance policy in which he/she is enrolled.

I authorize a licensed professional to dispense any medication recommended or prescribed by a physician to my child.

X Parent/Guardian _____ **Date:** _____

AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT HEMOPHILIA CAMP:

If your child has a minor health problem that can be treated with over the counter medications, ointments, bandages or splints, the camp nurses, physical therapists or physicians may provide care if you approve. A small supply of over-the-counter medications is available at camp. These medications are dispensed, as needed, under the standing orders of the Colorado HTC consulting physicians. Your personal physician does not need to sign for the medications listed below. The health history form is checked for allergies before any medication is given. If this list contains medications that you **do NOT want your child to receive**, draw a line through that medication with your initials. Medications stocked at camp are:

Taken by Mouth

Non-aspirin pain/fever relievers
[acetaminophen/Tylenol] - chewable,
liquid, gel caps and pills
Antihistamines (Benadryl)
Decongestants
Ibuprofen
Imodium (anti-diarrheal)
TUMS, Maalox or other antacid
Throat lozenges (Cepacol)

Creams & Ointments

Antibiotic cream or ointment
Cream for itching (Hydrocortisone)
Sunburn cream or gel (Aloe Vera)
Blistex
Silvadene (For Burns)
Athlete's foot cream (Lotrimin)
Calamine lotion
EMLA or other numbing cream
Sunscreens

Sprays & Other

Afrin/Neo-synephrine
Nasal Cease
Nasal QR
"Bug" spray
Throat spray (Chloraseptic)
First Aid Spray (Bactine)
Benadryl
Soap for poison oak (Teonut)

Brand names have been listed, but their generic equivalent or the same medication of a different brand name may be substituted.

Injectable Epinephrine is a prescription medication that is kept on site for use in the event of a life-threatening allergic reaction.

I authorize the Hemophilia Camp Medical Staff to dispense over-the-counter medication under the direction of the consulting physician's standing orders, as needed, to my child while at Hemophilia Camp.

X Parent/Guardian _____ **Date:** _____

INSTRUCTIONS FOR MEDICATION AT HEMOPHILIA CAMP:

- ☐ Parent consent must be in writing. [below]
- ☐ Prescription medication must be in its original container with a clear and accurate pharmacy label, which can be accepted as physician instructions. "Take as directed" or "as needed" is **NOT** specific and cannot be accepted as direction. *You can request a duplicate medicine label from your pharmacy.*
- ☐ If the directions on the bottle are different from what the physician is currently prescribing, written instruction is required from the physician. [next page]
- ☐ Non-prescription over the counter medication that your child's physician has recommended must be in its original labeled container. Please send over-the-counter medications with instructions on how you are giving the medicine to your child. Medication that is not in original containers will not be accepted.
- ☐ Place all medication required at camp in a zip-loc bag labeled with your child's name. Separate factor and other medications in their own zip-loc bag. Carry the medication bag separately and give it directly to the camp nurse or pharmacist.
 - EXCEPTIONS: Children requiring inhalers or insect sting kits may keep those items with them; however, this consent form must be signed and the medication must be shown to the nurse at the start of camp.
- ☐ At the end of Hemophilia Camp the camp nurse will return any left over medication to you. If you, or another adult assigned by you, does not pick up the medication when you pick up your child, it will be secured at the Hemophilia Treatment Center for you to pick up at a later time.

AUTHORIZATION FOR A CAMP NURSE OR PHYSICIAN TO ADMINISTER MEDICATION:

I request my child (camper's full name), _____, be given, or be assisted in taking the medicines listed below:

MEDICATIONS CAMPER MUST TAKE AT CAMP

Medication Name	Dose	Times/Days of the Week Taken
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

X Parent/Guardian _____ **Date:** _____

UNIVERSITY OF COLORADO

RELEASE OF RESPONSIBILITY, ASSUMPTION OF RISK AND WAIVER

PROGRAM: MILE HIGH HEMOPHILIA CAMP 2017 (7/16—7/21, 2017) at ROCKY MOUNTAIN VILLAGE

Please read this information completely before signing. The effect of this Release is to release the Regents of the University of Colorado, acting by and through the Hemophilia & Thrombosis Center (HTC), from any liability resulting from your child's participation in the program activity named above. In addition, this Release has the effect of waiving all claims for damages or losses against the Regents of the University of Colorado. Examples of daily activities are: arts and crafts, swimming, horseback riding sports and games, archer, in-camp campouts, computer lab, softball, hiking, tennis, fishing etc. Some campers may be given the opportunity for a day trip which is an excursion off camp property. Please refer to the 'Camp Activity Exclusion Form'.

In consideration of the HTC making arrangements for and permitting and assisting my child in participating in the above named program activities, I exercise my own free choice (or my child's) to participate voluntarily in activities, understand and assume all associated risks (physical injuries related to activities above including but not limited to: broken bones, head injuries, drowning, lacerations, and various other forms of trauma) , and agree to take due care during such participation. I hereby release and discharge, indemnify and hold harmless the Regents of the University of Colorado, a body corporate, and their member officers, agents, employees and any other persons or entities acting on their behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against all claims, demands, costs and expenses, and causes of action whatsoever, either in law or equity, arising out of or in any way connected with any loss and/or bodily injury and/or disability, arising from my participation in the above named program.

I understand that I am solely responsible for any costs arising out of any bodily injury and/or disability or property damage sustained through my child's participation in normal or unusual acts associated with the above named program.

I believe that my child is in good health, and affirm that my child's participation in the above named program activities will in no way aggravate any condition(s) present. If in doubt, I will seek further medical advice.

I consent that photographs, video or motion pictures may be taken of my child during the camp period, and that said photographs, video or motion pictures may be published in newspapers, magazines, television, publicity releases and/or other media, displayed in the clinic lobby, or used in program presentations by staff members of the HTC.

I have had sufficient time to review and seek explanation of the provisions contained above, have carefully read them, understand them fully, and agree to be bound by them. After careful deliberation, I voluntarily give my consent and agree to this Release, Assumption of Risk and Waiver. If the participant is under 18 years of age, the parent or guardian in consideration of this request accepts the above terms and grants permission for their child's participation.

X SIGNATURE: Parent or legal guardian

Date

AGREEMENT, CONSENT, WAIVER AND RELEASE FORM

EASTER SEAL SOCIETY OF COLORADO

PROGRAM: MILE HIGH HEMOPHILIA CAMP 2017 (7/16—7/21, 2017) at ROCKY MOUNTAIN VILLAGE

With the understanding that the Easter Seal Society of Colorado will make every reasonable effort to prevent accidents, injuries, or other mishaps, I acknowledge the following:

The undersigned agrees to indemnify and hold harmless the Easter Seals Colorado-Rocky Mountain Village for any and all claims, demands, costs, expenses, including reasonable attorney's fees that Easter Seals Colorado may suffer as a result of any claim, action, demand or judgment against it arising from the attendance at camp by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify the Easter Seals Colorado from any act of negligence or fault on the part of Easter Seals Colorado, its officers, agents or employees.

The undersigned does consent that photographs, video or motion pictures may be taken of the named applicant during the camp period, and that said photographs, video or motion pictures may be published in newspapers, magazines, television, publicity releases and/or other media.

The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.

The undersigned does hereby agree to allow participation of applicant in all camp activities (except those restricted)

The undersigned gives permission for the applicant to ride in vehicles operated or leased by the Easter Seals Colorado-Rocky Mountain Village.

The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the campers or others health and safety at camp or camp property. The undersigned further agrees to pick up the camper immediately upon being notified of such termination. **(Parents: Please discuss this behavioral contract with your child.)**

The undersigned agrees not to send the applicant to Rocky Mountain Village if he or she has been exposed to a contagious disease within three (3) weeks of the starting date of camp, and to notify Rocky Mountain Village if this situation arises.

If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present **written** authorization from the undersigned. I do hereby authorize (name, address, phone)

_____ to pick up the camper.

Please list anyone in particular you do NOT want to pick up your child.

In witness whereof I have hereunto executed this **Agreement, Consent & Release** on this date:

X SIGNATURE: Parent or legal guardian

Date

Camper Name: _____ 8

“GETTING TO KNOW YOU” FORM

In order to help your child feel comfortable at camp, it is helpful to have some background information so the camp directors and camp counselors may better understand your child and make plans for their week of camp.

FAMILY INFORMATION:

Child's Name: _____ Is there a nickname your child prefers? _____

Child resides with: _____ Both Parents _____ Mother _____ Father _____ Other: _____

Names and ages of brothers and sisters: _____

Are there any significant family or home-life situations that might affect your child's adjustment at camp? _____

GENERAL INFORMATION:

Has your child attended camp before? _____ Yes _____ No

If yes, what kind of camp? _____ Hemophilia Camp _____ Day Camp _____ Overnight Camp

Has your child ever been away from home overnight? _____ Yes _____ No

Comments: _____

Does your child have problems with bedwetting? _____ Yes _____ No

How do you handle your child's bedwetting: _____

Does your child have problems with sleepwalking, nightmares, frequent awakenings, fear of dark, etc? _____ Yes _____ No

What do you do to help them? _____

Is your child shy or does your child have difficulty getting along with other children? _____ Yes _____ No

Comments: _____

Does your child have problems with temper or other acting-out behavior? _____ Yes _____ No

If yes, please describe: _____

How do you deal with behavioral outbursts? _____

Has your child been diagnosed with ADHD, ADD or hyperactivity? _____ Yes _____ No

Comments: _____

Is he/she on medication for this? _____ Yes _____ No

Hemophilia Camp is not the appropriate week for a “drug holiday”. A note from the pediatrician is necessary for a drug holiday at camp.

Are there any fellow campers your child would or would *not* want to be grouped with specifically? (We will try to honor requests, but it is not always possible. _____

Do you have any other concerns or issues we should be aware of? Please give any additional information you can tell us that will help make your child's stay more enjoyable: _____

**University of Colorado Hemophilia Center & NHF Colorado
MILE HIGH HEALTH EXAMINATION**

Please note that all children attending camp must have a health examination by a licensed provider within the last year. This includes children who do not have a bleeding disorder.

Please have provider provide the information below.

My child was seen by the Colorado Hemophilia Treatment Center on: _____

My child has a scheduled appointment at the Colorado Hemophilia Treatment Center on: _____

LICENSED PRIMARY CARE PROVIDER HEALTH EXAMINATION:

This section must be completed and signed by a licensed provider [MD, DO, NP, PA] only if the camper has **NOT** had a comprehensive hemophilia clinic visit in the last year at the Colorado HTC or at an outreach clinic. If the camper has had a comprehensive hemophilia clinic visit in the last year, skip this page; the providers at the Colorado Hemophilia Center will attach a comprehensive report to your campers forms.

Provider Name (print): _____ **Date of Exam** _____

Licensed provider's comments and recommendations: (Give details and/or indicate management of chronic conditions, impression of general physical and emotional status, and limitations to activities please.)

By signing below, I indicate this person is in satisfactory condition and may engage in all usual activities except as noted.

Provider Signature: _____ **Date:** _____

CAMP ACTIVITY EXCLUSION FORM

Explanation of Camp Activity Policy

Each camper will be given the opportunity to participate in daily camp activities. Examples of daily activities are: arts and crafts, swimming, horseback riding, sports and games, archery, in-camp campouts, computer lab, softball, hiking, tennis, fishing etc. Some campers may be given the opportunity for a day trip. A day trip is an excursion off camp property that the camper signs up for at camp. Parents or guardians may indicate exclusions below if they do not want their child to participate in certain events.

This form must be completed for each camper.

Camper's Name _____

Initial here if your child has **no exclusions**. _____

I, the undersigned, have signed the liability release section of the camper application that allows full participation in all camp activities and day trips. I have checked the following activities in which my camper **may not** participate.

____ Arts and Crafts	____ Baseball/Softball	____ Swimming
____ Horseback riding	____ Tennis	____ Archery
____ Computer Lab	____ Sports and Games	____ Climbing Wall
____ Repelling	____ River Rafting	____ On-site camping
____ Off-site camping	____ Mountain biking	____ Golf
____ Fishing	____ Fly-fishing	____ Lure making
____ Photography	____ Off-site field trips not listed above	____ Hiking

X SIGNATURE _____ **DATE** _____



Checklist for Mile High Participants Easter Seals Program

The following is a checklist for completing the materials required to participate in the Mile High Camp Program. Check each item as you complete it, and return this form with your registration forms.

Forms are due by **June 1, 2017.**
****NO LATE REGISTRATIONS ACCEPTED.**

Checklist for Mile High Camp:

- ☐ Medical Information forms, filled out completely, pages 1-10. *(Make sure to read-through each consent before signing! Look for the X where we need your signature).*
- ☐ **Attach a copy of the camper's insurance card** – both front and back sides.
- ☐ **Immunization Records** *(parents: please provide a copy of up-to-date immunizations with your forms, or have your primary physician fax them to the NHFCO office, or fill out the immunizations section on page 2 of the medical forms).*
- ☐ Mile High Health Examination – If your camper needs a physical to complete the Mile High Camp process, please take page 9 to your appointment and have the physician fill it out. A physician must sign this form. If your camper has had/will have a comprehensive visit at the Colorado HTC in the months of 07/2016 to 07/2017, please provide that information on page 9. You do not need to do anything further.
- ☐ Registration fee in the amount of \$75.00:

☐ **Online**
www.cohemo.org

☐ **Check Enclosed**
Made out to NHF Colorado

☐ **Scholarship**
sjeffrey@hemophilia.org for form

- ☐ Send all materials to one of the following:

- Fax: 888-246-1758 **ATTN: Mile High Camp**
- Scan/Email rsvp@cohemo.org
- Mail: NHF Colorado
ATTN: Mile High Camp
 1385 S. Colorado Blvd. Suite #610
 Denver, CO 80222